Santa Clara Family Health Plan™

Long-Term Care Authorization Form

Utilization Management
Phone: **1-408-874-1821**
Fax: **1-408-376-3548**
Email: UMHelpDesk@scfhp.com

Today's date: _____

This form is for long-term care level of care authorization. Please complete and fax to Santa Clara Family Health Plan (SCFHP) Utilization Management (UM) department at **1-408-376-3548**.

If you have any questions please call the UM department at **1-408-874-1821** or refer to the Long-Term Care Authorization Form FAQs for additional details.

Member name: _____ **SCFHP ID:** _____

Member date of birth: _____

Line of business: ◯ Medi-Cal ◯ Cal MediConnect

Member admission date (current stay): _____

Diagnosis codes: _____

Requested service dates (MM/DD/YYYY): From: _____ To: _____

Type of long-term care request:

☐ Initial routine ☐ Re-authorization routine

☐ Initial retro ☐ Re-authorization retro

Type of contract:

☐ Subacute vent ☐ Subacute non-vent ☐ Level of care change

Referring provider name: _____

NPI#: _____

Phone: _____ **Fax:** _____

Servicing nursing facility name: _____

NPI#: _____

Phone: _____ **Fax:** _____

Contact name: _____

REQUIRED DOCUMENTATION: Submission of <u>all attachments is required</u> for authorization approval:

☐ Face sheet
☐ Care plan (treatment plan, discharge plan, etc.)
☐ Medicare denial letter (if applicable)
☐ Physician's current orders, signed and dated